UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Dominique Williams

Write the full name of each plaintiff.

20-cv-10571
(Include case number if one has been assigned)

-against-

Officer/Lt. Lohard of Newburgh NYPD
Officer John Doe of Newburgh NYPD
City of Newburgh NY et al.;

Write the full name of each defendant. If you need more space, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed above must be identical to those contained in Section II.

COMPLAINT

Do you want a jury trial?
☐ Yes ☐ No

NOTICE

The public can access electronic court files. For privacy and security reasons, papers filed with the court should therefore *not* contain: an individual's full social security number or full birth date; the full name of a person known to be a minor; or a complete financial account number. A filing may include *only*: the last four digits of a social security number; the year of an individual's birth; a minor's initials; and the last four digits of a financial account number. See Federal Rule of Civil Procedure 5.2.

Here are Violations of my Federal Constitutional Rights
Attachment & Complaints

I. BASIS FOR JURISDICTION

Federal courts are courts of limited jurisdiction (limited power). Generally, only two types of cases can be heard in federal court: cases involving a federal question and cases involving diversity of citizenship of the parties. Under 28 U.S.C. § 1331, a case arising under the United States Constitution or federal laws or treaties is a federal question case. Under 28 U.S.C. § 1332, a case in which a citizen of one State sues a citizen of another State or nation, and the amount in controversy is more than $75,000, is a diversity case. In a diversity case, no defendant may be a citizen of the same State as any plaintiff.

What is the basis for federal-court jurisdiction in your case?

☑ Federal Question

☐ Diversity of Citizenship

A. If you checked Federal Question

Which of your federal constitutional or federal statutory rights have been violated?

Police Brotality, Excessive Force, Illegal Detainment under Federal CPL Guidelines Clear Violation of My Federal Constitutional Rights

B. If you checked Diversity of Citizenship

1. Citizenship of the parties

Of what State is each party a citizen?

The plaintiff, Dominique Williams, is a citizen of the State of
(Plaintiff's name)

New York
(State in which the person resides and intends to remain.)

or, if not lawfully admitted for permanent residence in the United States, a citizen or subject of the foreign state of

If more than one plaintiff is named in the complaint, attach additional pages providing information for each additional plaintiff.

If the defendant is an individual:

The defendant, Lt Lohard & Officer John Doe is a citizen of the State of
(Defendant's name)

New York, City of Newburgh County of Orange

or, if not lawfully admitted for permanent residence in the United States, a citizen or subject of the foreign state of

_____.

If the defendant is a corporation:

The defendant, _____, is incorporated under the laws of

the State of _____

and has its principal place of business in the State of _____

or is incorporated under the laws of (foreign state) _____

and has its principal place of business in _____.

If more than one defendant is named in the complaint, attach additional pages providing information for each additional defendant.

II. PARTIES

A. Plaintiff Information

Provide the following information for each plaintiff named in the complaint. Attach additional pages if needed.

Dominique D Williams
First Name Middle Initial Last Name

#110 Wells Farm Rd
Street Address

Orange, Goshen NY 10924
County, City State Zip Code

n/a
Telephone Number

n/a
Email Address (if available)

B. Defendant Information

To the best of your ability, provide addresses where each defendant may be served. If the correct information is not provided, it could delay or prevent service of the complaint on the defendant. Make sure that the defendants listed below are the same as those listed in the caption. Attach additional pages if needed.

Defendant 1: Lt Officer Lohard
First Name Last Name
Lt of Newburgh City Police Dept.
Current Job Title (or other identifying information)
#55 Broadway Newburgh NY
Current Work Address (or other address where defendant may be served)
Orange Newburgh NY 12550
County, City State Zip Code

Defendant 2: Jhon Doe
First Name Last Name
Officer Newburgh City Police Dept
Current Job Title (or other identifying information)
#55 Broadway Newburgh NY
Current Work Address (or other address where defendant may be served)
Orange Newburgh NY 12550
County, City State Zip Code

Defendant 3: City of Newburgh
First Name Last Name
in it's entirety connected of/to NBPD
Current Job Title (or other identifying information)

Current Work Address (or other address where defendant may be served)
Orange Newburgh NY 12550
County, City State Zip Code

Defendant 4:

First Name Last Name

Current Job Title (or other identifying information)

Current Work Address (or other address where defendant may be served)

County, City State Zip Code

III. STATEMENT OF CLAIM

Place(s) of occurrence: St Lukes Hospital & 1st Street both of City of Newburgh NY 12550

Date(s) of occurrence: 11-3-18 into 11-4-18 am hours

FACTS:

State here briefly the FACTS that support your case. Describe what happened, how you were harmed, and what each defendant personally did or failed to do that harmed you. Attach additional pages if needed.

I am a victim of police brutality, excessive force & illegal detainments under Federal CPL Guidelines & procedure's. Which include but not limited to proof & documentations

"See Attachments"

To which include my admittances to St Lukes Hospital & discharges / Legal Attorney's requests / Injury Diagrams w/ time & occurances (multiple reports) / Injury Photo's / Drs Testimonial report / Hand written testimony of Plaintiff /

"I was Shot & Carced for, only to have my wound & dignity brutalized upon my departure from a hospital. I don't wish this on no Man & pray justice's hammer Comes down on the Officer's that Violated me!"

INJURIES:

If you were injured as a result of these actions, describe your injuries and what medical treatment, if any, you required and received.

(See attachments) Medical records & reports applied to with as proof. I have permanent physical damage due to these actions of Both said officers & I want Compensation & Justice.

IV. RELIEF

State briefly what money damages or other relief you want the court to order.

I want compensation for all my pain & suffering physical & mental & all other justice & relief as your Court deems must fit & definitly proper under these circumstances. I want all money for my Dr bills & nothing short of compesation for all my permanent injuries. "My arm & stitches were still fresh & had not even begun to heal before the (2) said officers re-opened my wound & caused more damage" I want full Compensation!

V. PLAINTIFF'S CERTIFICATION AND WARNINGS

By signing below, I certify to the best of my knowledge, information, and belief that: (1) the complaint is not being presented for an improper purpose (such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation); (2) the claims are supported by existing law or by a nonfrivolous argument to change existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Federal Rule of Civil Procedure 11.

I agree to notify the Clerk's Office in writing of any changes to my mailing address. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Each Plaintiff must sign and date the complaint. Attach additional pages if necessary. If seeking to proceed without prepayment of fees, each plaintiff must also submit an IFP application.

12-4-20
Dated

D. Williams
Plaintiff's Signature

Domingue | D | Williams
First Name | Middle Initial | Last Name

#110 Wells Farm Rd
Street Address

Orange, Goshen | NY | 10924
County, City | State | Zip Code

n/a
Telephone Number

n/a
Email Address (if available)

I have read the Pro Se (Nonprisoner) Consent to Receive Documents Electronically:
☑ Yes ☐ No

If you do consent to receive documents electronically, submit the completed form with your complaint. If you do not consent, please do not attach the form.

"I do not Consent I am a pre-Trial Detainee pro-se applicant to which I need my Documents 1st class mail"

-Testimony-

To whom it may Concern:

I Dominique Williams am forwarding this Federal complaint against the City of Newburgh & it's Sworn officers for their clear & unlawfull violations of My Constitutional Rights as an American Protected Citizen of the United States.

-Brief:-

On November 3rd, 2018 I the plaintiff (Dominique Williams) unfortunatly suffered a life altering severe gunshot wound to my right bicep. On that same evening I admitted myself into St. Lukes Cornwall Hospital located on #70 Dubois St in the City of Newburgh NY 12550, for the gunshot wound as for at that time it was the only injury I had sustained. In accordance after all the proper procedures & protocals were executed by the staff, RN's & Dr. Andrew Suleiman I was given my formal legitamate & required discharge papers, to with were signed off by Dr. Andrew Soleiman as true witness for my given allowance to exit the premises of St. Lukes Hospital. Upon my release & walk home from the said Hospital I was brutaly tackled, assaulted & beaten by one officer (Jhon Doe) to with other officers witnessed as I was bumbarded from behind without so much as even a warning. By No means was this force & abuse of power warranted due to the fact, which is, I was already severly wounded & nor was I resisting or posed any threat to with I (the plaintiff) should have remained un-molested by (Jhon Doe). Now I (the plaintiff) suffered from more damage to my already wounded body. (See attachments). After the abuse & I was brought to my beaten feet to stand I immediatly Identified One Lt. officer Lohard of Newburgh City PD. Without fail I asked for the abusive officers name & Shield # as he (Jhon Doe) was now behind me holding me still excessivly in handcuffs. Lt Lohard & Jhon Doe both Denied me the information I am allowed by NY Stat

& that I repeatedly asked/requested be given to me, but still the result, was deny me JhonDoes name title & badge#! I explained to them both they are & have violated my rights & I won't stand for this treatment. In response & time Lt. Lohard asked me & I quote "Soo why did you leave the hospital?" So I (plaintiff) replyed I was discharged & if this is the reason you have allowed me to be assaulted your all in serious trouble I know my rights!". Mind you all the while I had my discharge papers in hand, but yet & still both participating officers refused to oblige me & look to see that I was telling the truth. Now pain excrusiating, with my wound re-opened, bleeding on top of more wounds Officer (JhonDoe) has inflicted upon me for no just cause (see attachments exihits A-D) as I was beaten & experianced harsh Police brutality after a severe & already traumatizing event of being shot to with there was absolutly no reason for myself to be victimized with a beating by Officer (JhonDoe), now proceeding the abuse continued as Lt. Lohard forcefully grabbed, pushed & dragged me all the way back to the Hospital of my previous treatment & discharge to which my Dr. Andrew Suleiman was beyond shocked & is proof to witness & testify to his demand for Lt Lohard to uncuff me for as I was properly discharged. Upon my 2nd arrival at St Lukes in the same day Dr. Andrew Suleiman re-stitched my gunshot wound as well as cared & treated my new wounds inflicted by Lt. Lohar & Officer (JhonDoe) at St Lukes Hospital.

-Conclusion:-

The City of Newburgh's officers Lt. Lohard & JhonDoe have both violated my rights & abused their powers as officers of the law. Lt Lohard expressed no regard to my rights & used excessive force dragging me back to the hospital as well as

illegally detained me (plaintiff) as I broke no laws to NY State & no rules in accordance to NY state Hospital procedures. Officer (John Doe) completely has brought shame to his title as Peace Officer by actions of disgust & unjust brutality on me & also has victimized me as I was already wounded, without posing no immediate threat walking home in pain to rest. These two City of Newburgh Officers have broken the laws they swore to uphold & should be punished & made to answer for heinous actions.

Therefore all relief should be granted to I (the plaintiff) & all others as the Court deems fit & proper

Respectfully Submitted

X D. Williams

TERRENCE DOUGHTY
Notary Public, State of New York
Registration #01DO6173077
Qualified In Orange County
Commission Expires Sept. 10, 2023

The foregoing document was acknowledged
before me this 4 day of December 2020

Notary Public

THE KLEISTER LAW GROUP

"Your Neighborhood Law Firm"

CHRISTOPHER B. KLEISTER
Attorney at Law
JOHN A. HURBAN
Of Counsel

JENNIFER L. McCARTHY
Paralegal

L638391

July 1, 2020

11/3-11/4/18 en
11/4/18 en

VIA FACSIMILE (845)568-2917 &
FIRST CLASS MAIL
SLCH Medical Records Department
ATTN: IOD
70 Dubois Street
Newburgh, NY 12550

Re: Dominique Williams (d.o.b.: 8/17/1996)

Dear Sir/Madam:

Enclosed please find an authorization signed by my client Dominique Williams to release his medical records to my office.

Thank you for your anticipated cooperation in this matter.

Very truly yours,

THE KLEISTER LAW GROUP

By: Christopher B. Kleister, Esq.

CBK/lmf
Enc.
CC: Dominique Williams

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Dominique Williams	8-17-96	
Patient Address		
110 Wells Farm Rd Goshen, NY 10924 CCT		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in Item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

Monte fiore, St Lukes 70 Dubois St Newburgh NY 12550

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

Kleister Law group 85 East main street Washington ville N.Y 10992

7. Purpose for Release of Information:

Legal matter

8. Unless previously revoked by me, the specific information below may be disclosed from: 11-3-18 (INSERT START DATE) until 11-6-18 (INSERT EXPIRATION DATE OR EVENT)

☑ All health information (written and oral), except:

All / I want all my medical Records from the above date

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Dominique Williams — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — 6-25-20 DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

Christopher Kleister Esq. — STAFF PERSON'S NAME AND TITLE — SIGNATURE — 6/25/20 DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DOH-5032 (4/11)

Made Fillable by eForms

St. Luke's Cornwall Hospital

Patient Name: WILLIAMS,DOMINIQUE D
Unit Number: L638391
Account Number: H01850213

Patient Signature Page

Patient Name: WILLIAMS,DOMINIQUE D **Date of Birth: 08/17/1996**

Guardian Name:

The above-named patient and/or guardian has received the following:

Patient Visit Report
Patient Instructions:
Discharge Instructions for Laceration Repair
Hydrocodone Combination Products
Forms:
ED EMPLOYER/SCHOOL INFO
DIAGNOSTIC ORDERS

The Doctor to whom you have been referred may not be covered by your insurance plan and you may be required to pay for the office visit. Since there are many different insurance plans and not every physician participates in every plan, we advise that you contact your insurance company to verify which physicians are in your plan.

I agree that all diagnostic results and tests were reviewed with me at discharge and am aware of any pending tests.

Please make sure you have read through this information before signing.

I have read and understand the instructions given to me by my caregivers.

DOMINIQUE D WILLIAMS
Print Patient Name

Patient (or Guardian) Signature Date Time

Caregiver/RN/Doctor Signature Date Time

St. Luke's Cornwall Hospital
EMERGENCY ROOM NOTE

PATIENT: WILLIAMS,DOMINIQUE D
ACCOUNT #: H01850213
UNIT #: L638391
SEX: M
MD,ASHIKKUMAR A.
DOB: 08/17/96 AGE: 22

STATUS: DEP ER
SERVICE DT: 11/04/18
LOCATION: L.ER
PCP PHYS: RAVAL

General Medical HPI

Current History

Meds taken at home

Active Scripts

IBUPROFEN (MOTRIN) 600 MG PO Q4-6H PRN PAIN/FEVER
IBUPROFEN (MOTRIN) 600 MG PO Q4-6H PRN PAIN/FEVER #20 TABLET
Prov: 07/20/18
CEPHALEXIN 500 MG PO Q8HR
CEPHALEXIN 500 MG PO Q8HR #9 CAP
Prov: 11/04/18
Hydrocodone/Acetaminophen (Hydrocodone-Acetamin 5-325 MG) 1 TAB PO Q4H PRN pain
Hydrocodone/Acetaminophen (Hydrocodone-Acetamin 5-325 MG) 1 TAB PO Q4H PRN pain #10 TABLET
Prov: 11/04/18

Allergies

Coded Allergies:

No Known Drug Allergies (11/06/12)

General

Chief Complaint WOUND CHECK

Greet time

0229

Date seen 11/04/18

Time seen 0235

History from patient

Past Medical/Family History

Prior Medical History DENIES

Surg Hist/Past Hospitalization

DENIES

Social history lives with family

History of Present Illness

Initial Comments

Pt is a 22 y/o M who presents to the ED reporting being in the ED 30 min PTA for a GSW to RUE which was repaired. Pt was d/c and as he was leaving, states alleged altercation with PD, reopening the wound and presents now for a wound check, [redacted] any other injuries or current complaints.

Portions of this section were scribed by SULEIMAN,ANDREW on 11/04/18 at 0235

Physical Exam

Nursing assessment reviewed Yes

Physical Exam

Comment

ROS
Gen: no chills or fever
Eyes: no discharge, no change vision
ENT: no sore throat, no rhinitis
Cardiac: no chest pain, no palpitations
Resp: no sob, no cough
GI: no abd pain, no nausea, vomiting, or diarrhea
GU: no dysuria, urgency, change in color
MS: + wound check
Skin: no rash, no itch
Neuro: no dizziness, headache, no focal paralysis or paresthesia
Psych: no hallucinations, no depression
Heme: no bruising, no bleeding
Other relevant systems reviewed and negative

Physical brief exam
Vital signs reviewed, please refer to nurses note
Constitutional: No distress, warm, dry, well nourished, nontoxic

MEDICAL INCIDENT REPORT [redacted]

PERSON INVOLVED (LAST NAME, FIRST, MIDDLE INITIAL)	BOOKING NUMBER	SEX	AGE	DATE OF BIRTH
Williams, Dominique	18-4771	☑ MALE ☐ FEMALE	22	8/17/96

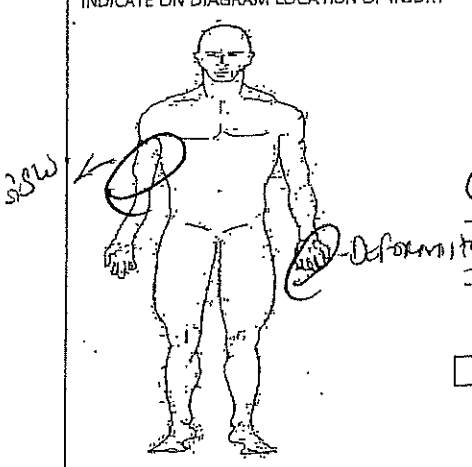
DATE OF INCIDENT	TIME OF INCIDENT	EXACT LOCATION OF INCIDENT
11/05/18	☐ A.M. ☑ P.M.	MED / CELL

☑ INMATE	PROPERTY INVOLVED (IF YES DESCRIBE) ☐ YES ☑ NO	WAS PERSON AUTHORIZED TO BE AT THE LOCATION OF THE INCIDENT? ☐ YES ☐ NO
☐ DETAINEE	EQUIPMENT INVOLVED (IF YES DESCRIBE) ☐ YES ☐ NO	
☐ PRE SEGREGATION	TYPE OF SEGREGATION ☐ DISCIPLINARY ☐ ADMINISTRATIVE ☐ PROTECTIVE CUSTODY ☐ Paperwork Complete	
☐ HOSPITAL RETURN	HOSPITAL PAPERWORK RECEIVED: ☐ YES ☐ NO	SPECIAL HOUSING REQUESTED FOR HOSPITAL RETURNING (IF YES DESCRIBE) ☐ YES ☐ NO

DESCRIBE EXACTLY WHAT HAPPENED: WHAT CAUSES WERE, IF INJURED: STATE PART OF BODY INJURED. IF PROPERTY OF EQUIPMENT WAS DAMAGED STATE THE DAMAGE:
PBI: GSW (R) ARM, 13 stitches. (L) middle finger deformity.

	WHEN	WHERE	NURSE NAME / PHYSICIAN NAME / BY WHOM
WAS INMATE/DETAINEE INVOLVED SEEN BY A NURSE? ☑ YES ☐ NO	11/5/18 @ 1755	MED	A. DeLaCruz
WAS INMATE/DETAINEE SEEN BY A PHYSICIAN? ☑ YES ☐ NO	11/5/18	MED.	DR. KHAN
WAS FIRST AID ADMINISTERED? ☑ YES ☐ NO	11/5/18	MED.	RN S. S. RN
WAS INMATE/DETAINEE INVOLVED TAKEN TO A HOSPITAL? ☐ YES ☑ NO			

INDICATE ON DIAGRAM LOCATION OF INJURY

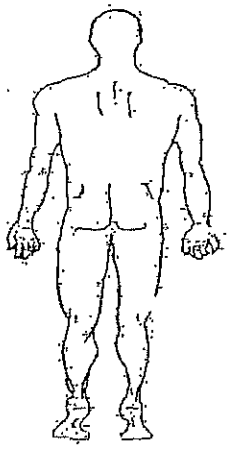


INDICATE TYPE OF INJURY
☐ LACERATION ☐ HEMATOMA
☐ ABRASION ☐ BURN
☐ NON APPARENT ☐ OTHER (SPECIFY)

GSW

Deformity

ACCIDENT
☐ FATAL ☑ NON-FATAL



NURSE/PHYSICIAN'S COMMENTS (CHIEF COMPLAINT)
Seen by RN.

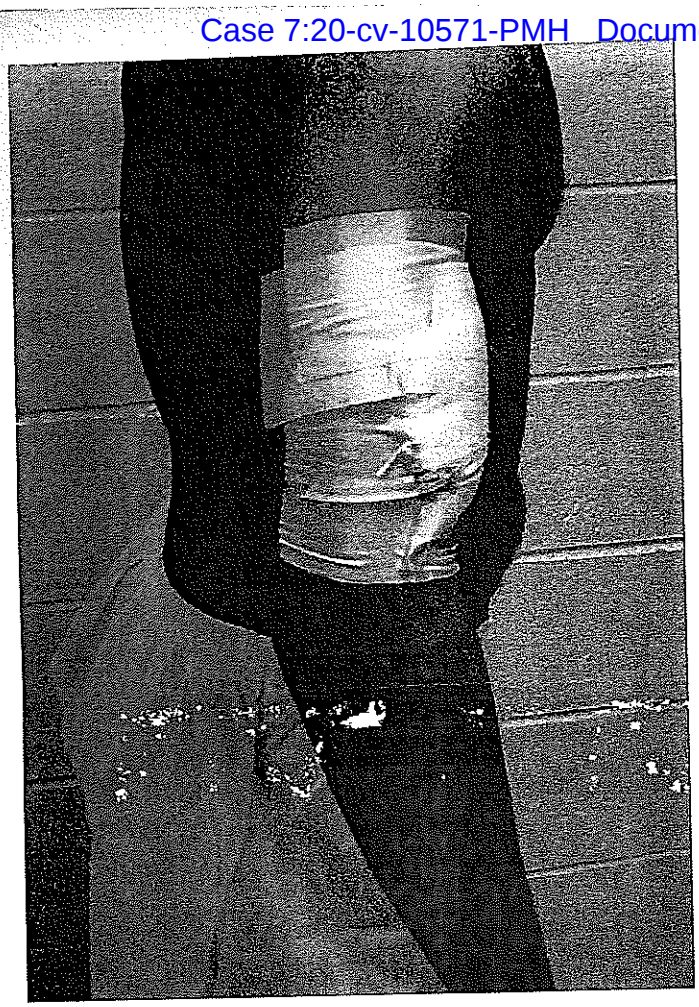
DATE OF ASSESSMENT	IF ASSESSMENT DATE IS NOT THE SAME DATE AS THE INCIDENT STATE REASON
11/5/18	

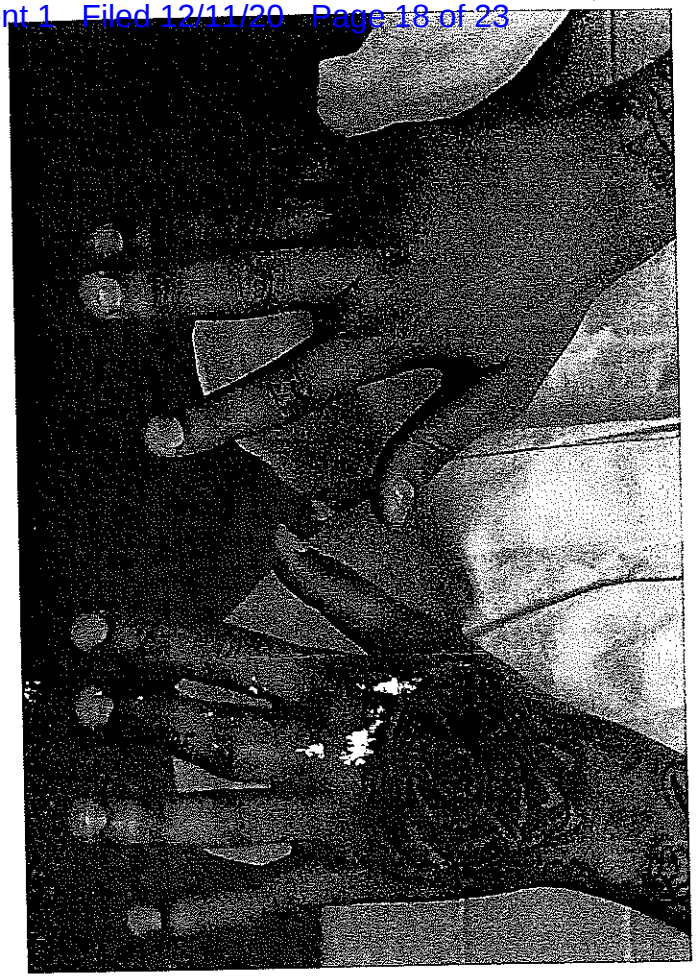
TITLE AND SIGNATURE OF PERSON PREPARING THE REPORT

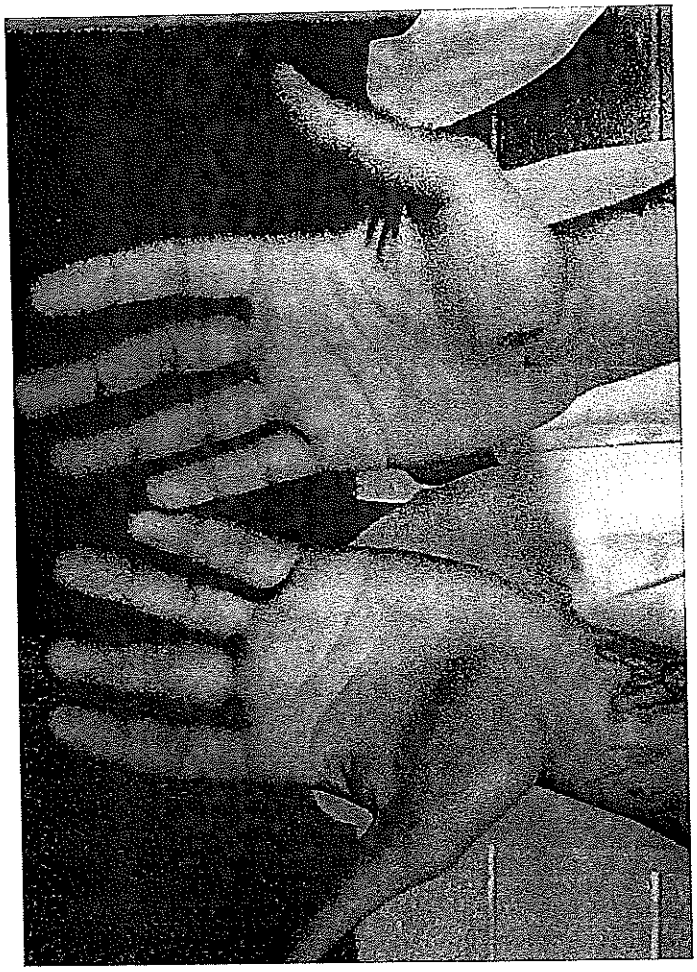
OFFICER NAME, SIGNATURE AND SHIELD NUMBER
Barlow Barlow #253

NOTE: A COPY OF ALL MEDICAL INCIDENT REPORTS WILL BE PROVIDED TO THE FACILITY SHIFT COMMANDER

Exhibit-A







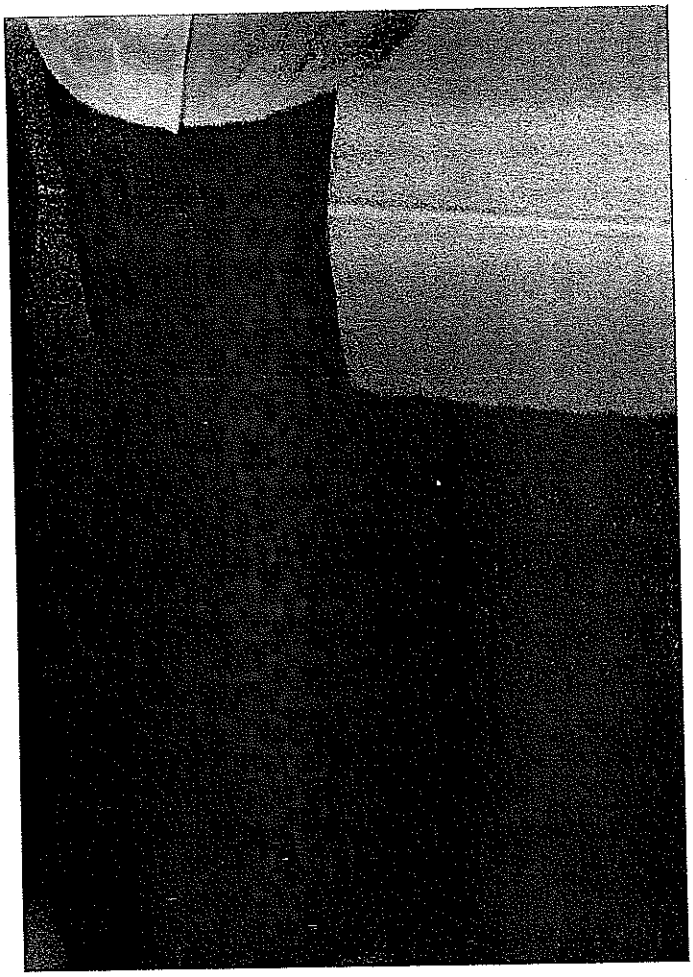
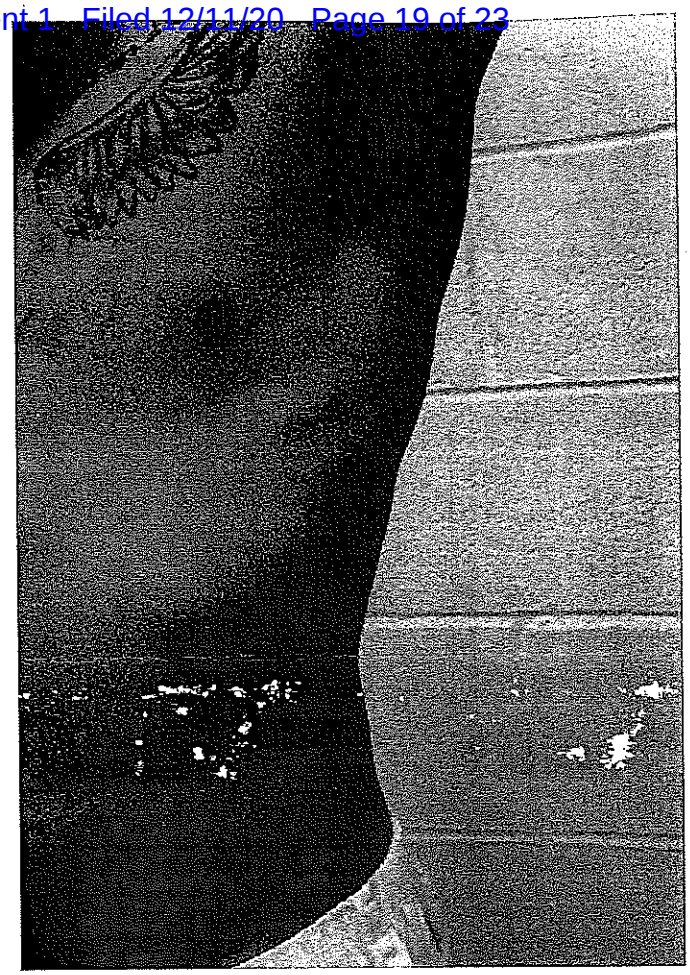
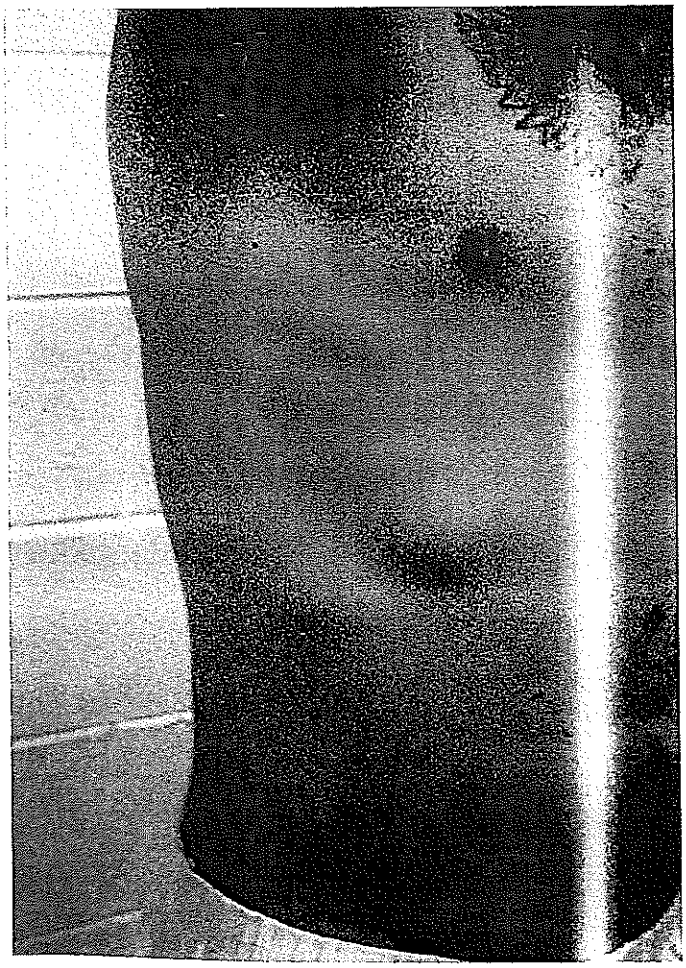


Exhibit-B





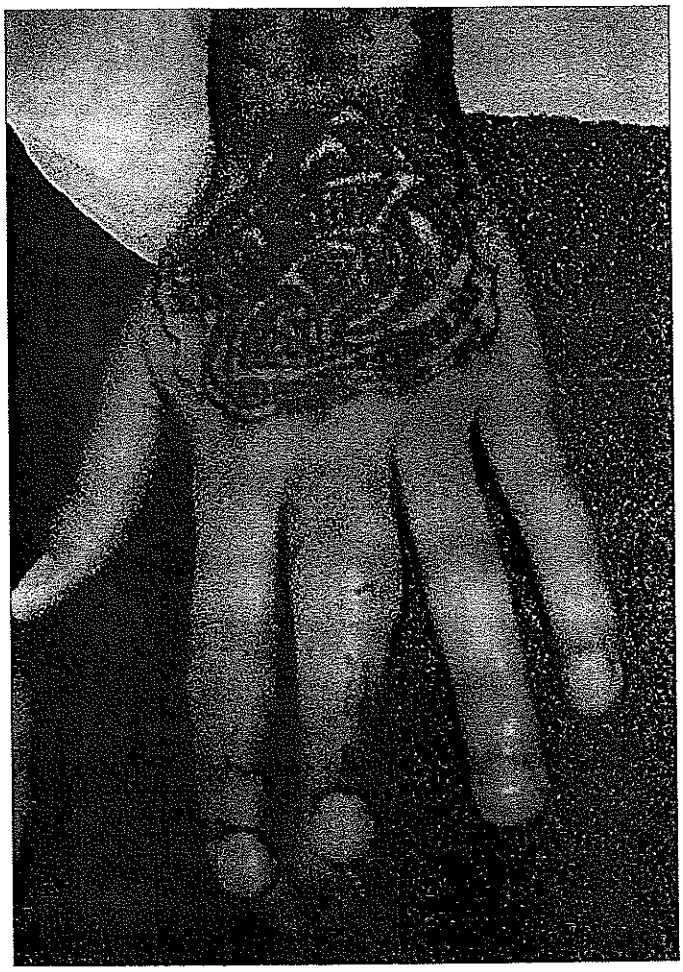
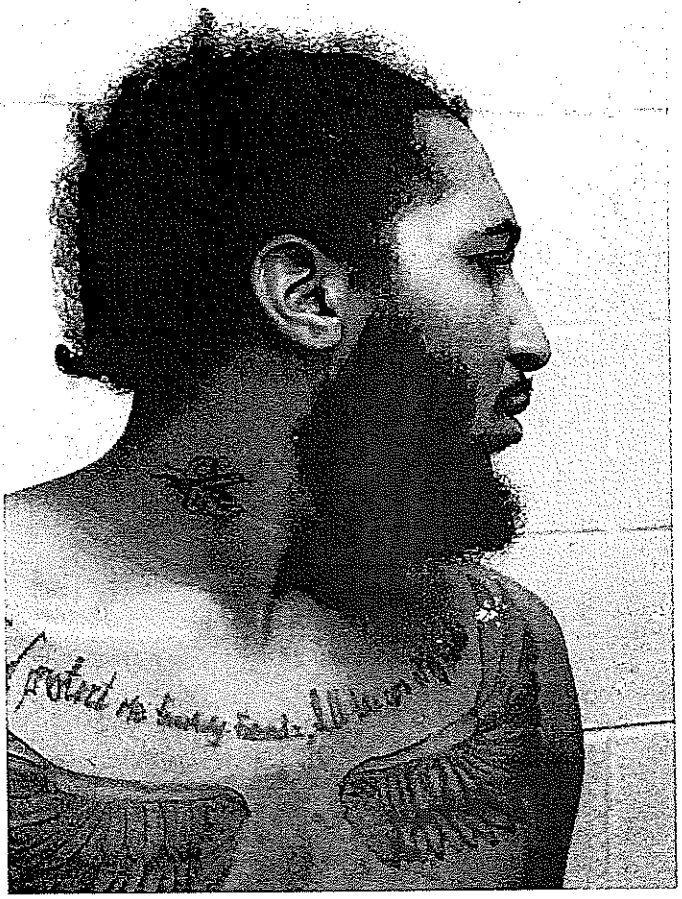
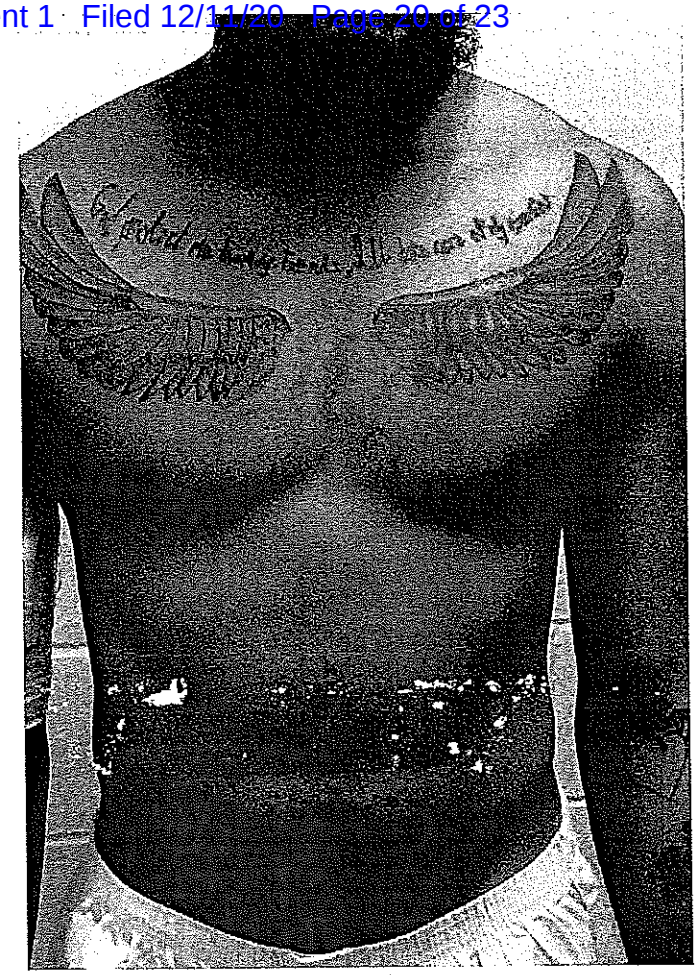
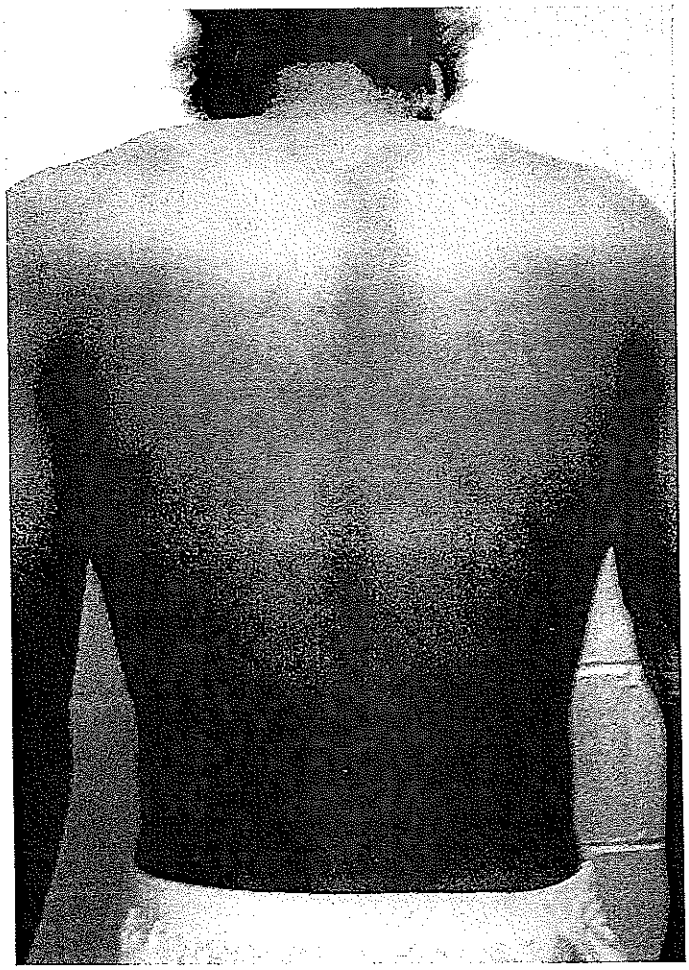


Exhibit-C







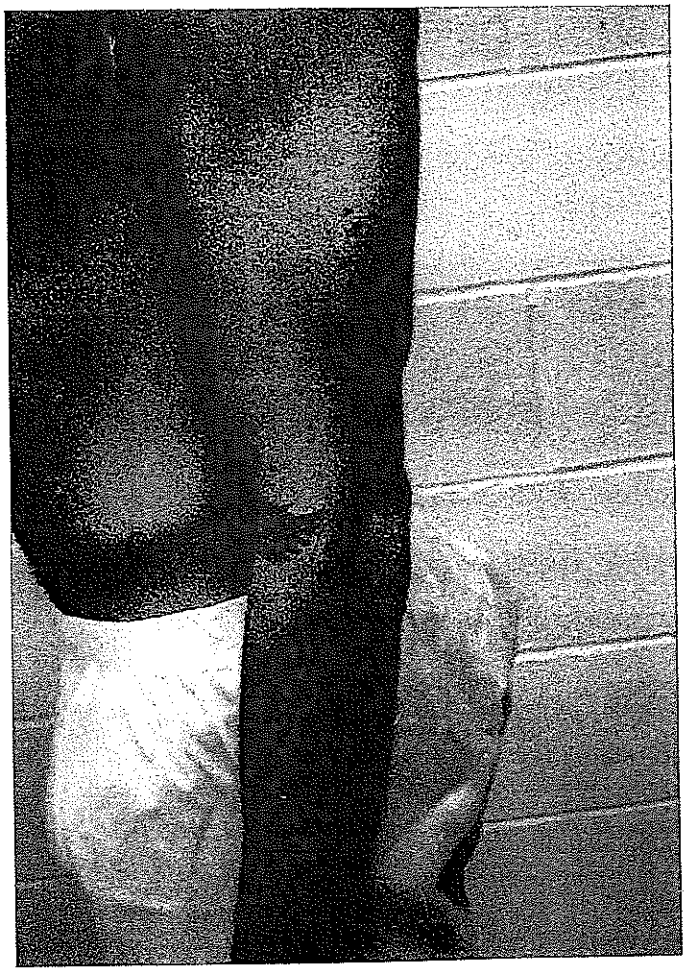
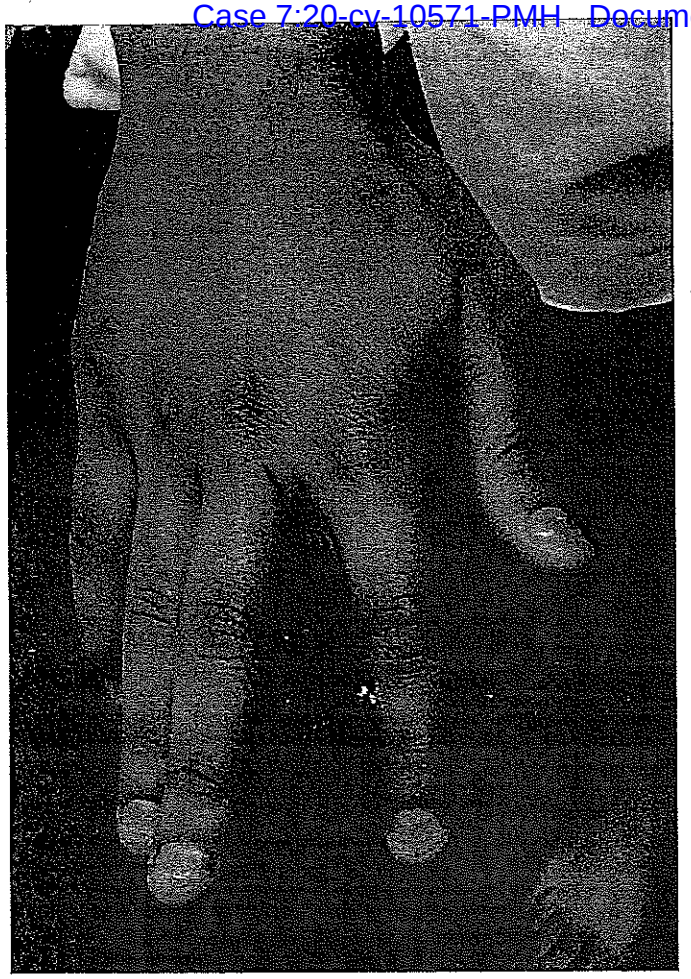
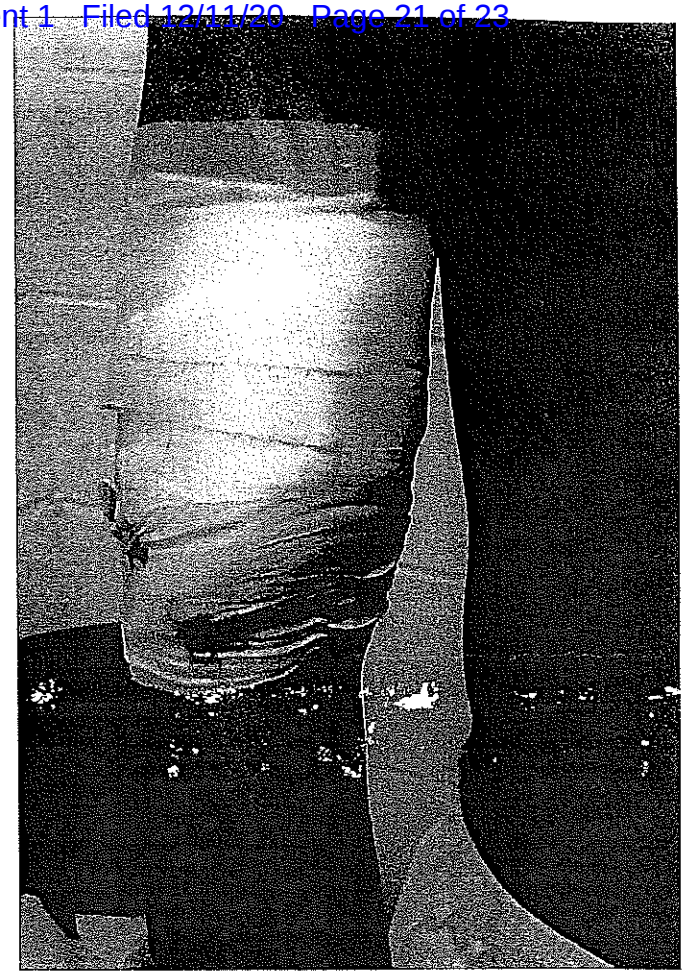
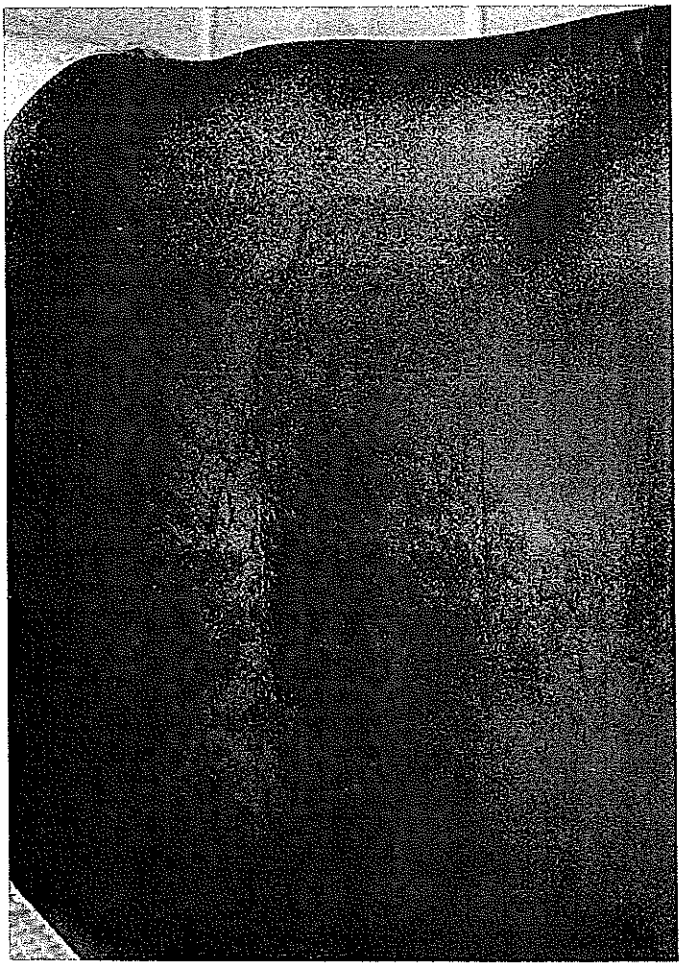
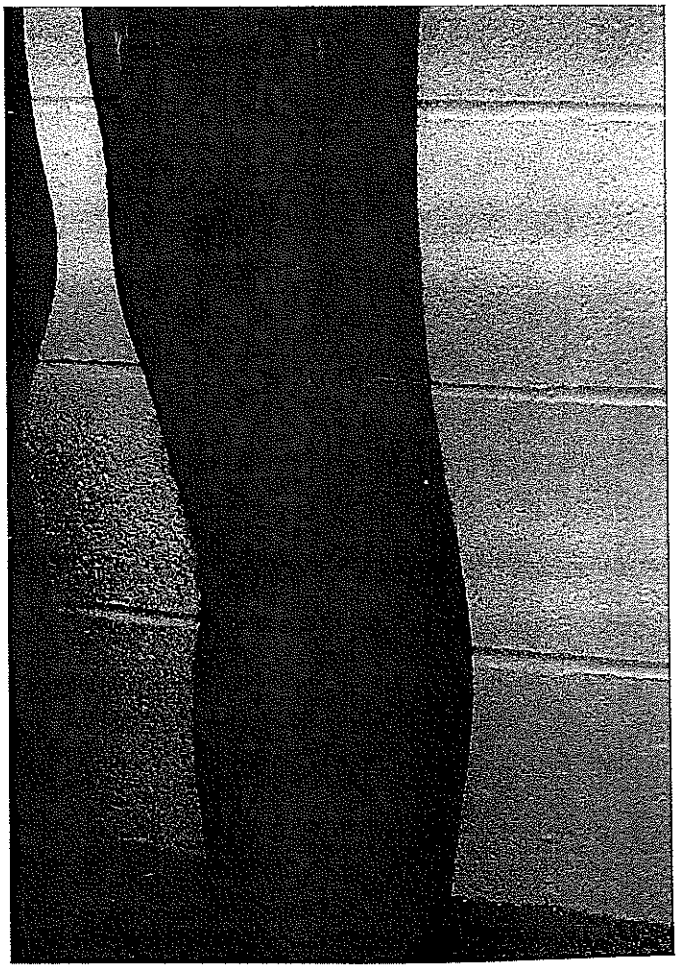


Exhibit-D









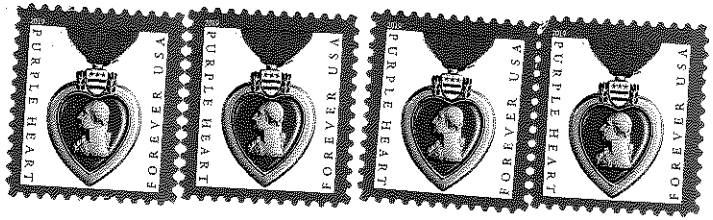
11-4-2020

I Dominique Williams
have written this Complaint
File to start my suit against
The city of Newburgh
& It's officers described, So
Please help me to start
as I seek Justice for
Clear Violations of my Protected
Federal Constitutional Rights

Thank You

ORANGE COUNTY JAIL
110 WELLS FARM ROAD
GOSHEN, NEW YORK 10924
Dominique Williams 2018-04771

D2



United States District Court
Southern District of New York
-U.S Courthouse-
500 Pearl Street
New York NY 10007

Pro Se
SM

(In-Take Unit
Extremely Important)
LEGAL MAIL